FAX

TO: RADM John Babb

FAX: 301-443-5146

PHONE: 301-443-3114

FROM: _____

PHONE: _____

SUBJECT: Summer CCRF Training Opportunities APPLICATION

Specific Course Name: _____

THE ENCLOSED APPLICATION WILL NOT BE CONSIDERED UNLESS ALL THE ITEMS BELOW ARE FULLY COMPLETED. PLEASE BE SURE YOU INCLUDE ALL THE ITEMS LISTED BELOW.

___ Training Application

___ Medical Screening Form

___ Dietary Restrictions Form

WATCH THE COURSE APPLICATION DEADLINES – YOUR APPLICATION WILL NOT BE CONSIDERED IF IT IS RECEIVED AFTER THE DEADLINE.

2002 CCRF Training Program Application

Further instructions on travel and training arrangements will be provided after your acceptance.

Course Selection – *Please select one course and date*			
Emergency Coordinator – Augmentee (EC-A)	National Pharmaceutical Stockpile - Basic	Liaison Officer Training (LNO)	Mass Vaccination Training
◯ Jun 10-14	◯ Jul 15-19	◯ Jul 16-19	◯ Aug 26-29
◯ Jul 8-12	◯ Aug 5-9	◯ Aug 12-16	
◯ Aug 12-16	◯ Sep 9-13		

Applicant Information	
Name:	
SSN:	
Rank:	
Category/CCRF Role:	
Gender:	Male / Female
Date of Birth:	/ /
Home Address:	
Home Phone:	
Home Email:	
Airport of Depature: *Please be specific (POV if driving)*	
Duty Station:	
Work Phone:	
Work FAX:	
Work Email:	

Supervisor Approval	
By signing below, I acknowledge tha I am giving my permission for the officer named above to attend this course. I understand that this may reqire that officer to travel from home on Monday and return no earler than Friday and tha t OEP will pay all costs associated with this training.	
Supervisor Name	Supervisor Signature

NOTICE: The Privacy Act, 5 USC 522a, requires that federal agencies inform individuals whether the disclosure is mandatory or voluntary. Your Social Security Number (SSN) will be used to identify you precisely when it is necessary.

WASTREN, Inc.
A Multi-Service Corporation

Responder,

Please review the enclosed menu, if you have a special Dietary requirement, please let us know as soon as possible by filling out the form below and faxing back with your completed training application.

☐ Yes I am a Vegetarian

☐ Yes I have the following special requirements. (e.g. seafood, allergy)

_____

_____

☐ None I do not have any special dietary requirements

NAME:

_____

NOTE: Please review menu on reverse side, if you have any dietary requirements please fill out the front of the form. Thank you for helping us serve you better.

WASTREN, Inc.

Anniston Form 20 (11-99)

U.S. PUBLIC HEALTH SERVICE - NOBLE TRAINING CENTER

Medical Screening Form

Name: _____ Date: _____
First MI Last Month / Day / Year

Signature: _____

Course Requested: _____

1. Responders under consideration for attendance at the USPHS Noble Training Center, Integrated Health and Medical WMD Training Program must complete this medical screening questionnaire.

2. Do you now or have you previously been treated for or experienced:
(Please check all that apply)

a. Heart Disease or Condition	YES	☐	NO	☐
b. Chest Pain	YES	☐	NO	☐
c. Frequent Fainting	YES	☐	NO	☐
d. Asthma	YES	☐	NO	☐
e. Emphysema	YES	☐	NO	☐
f. Chronic Bronchitis	YES	☐	NO	☐
g. Other Lung or Chest Problems	YES	☐	NO	☐
h. Perforated Eardrum	YES	☐	NO	☐
i. Seizures or Epilepsy	YES	☐	NO	☐
j. Diabetes	YES	☐	NO	☐
k. Heat Injury (last 12 months)	YES	☐	NO	☐
l. Hyperventilated while in a PPE	YES	☐	NO	☐
m. Claustrophobia	YES	☐	NO	☐
n. Taking narcotic medication	YES	☐	NO	☐
o. Taking any chronic medications	YES	☐	NO	☐
p. Now have open wound or sutures	YES	☐	NO	☐

Any question with a YES answer requires an explanation by the responder, including date last seen by a provider and stability of condition.

_____

_____

_____

3. I certify that I am in appropriate health to be physically active and perform tasks in any of the following: extreme heat, personal protective clothing and/or respirator systems.

☐ YES ☐ NO If No, list restrictions: _____

_____

_____